

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

July 16, 2019

Mr. Gary Havican, Administrator
Hospital Of Central Connecticut, The
100 Grand Street
New Britain, CT 06050

Dear Mr. Havican:

This is an amended edition of the violation letter originally dated July 8, 2019.

An unannounced visit was made to Hospital Of Central Connecticut, The on June 5, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by July 18, 2019.

The plan of correction shall include:

- (1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
- (2) the date each such corrective measure or change by the institution is effective;
- (3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
- (4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **July 18, 2019** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

An office conference has been scheduled for **August 5, 2019 at 10:00 AM** in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to

Phone: (860) 509-7400 • Fax: (860) 509-7543

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410 Capitol Avenue, P.O. Box 340308

Hartford, Connecticut 06134-0308

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DATE OF VISIT: June 5, 2019

**THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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WERE IDENTIFIED**

retain legal representation, your attorney may accompany you to this meeting.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan H. Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN/PAB:jf:

Complaint #25446

DATE OF VISIT: June 5, 2019

**THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT
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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e)
Nursing Services (1) and/or (i) General (6) and/or CGS 19a-550.

1. *Based on clinical record review, interview and policy review for 1 of 3 patients (Patient #1) on the psychiatric unit, the facility failed to ensure that the patient was free from abuse and seclusion and/or that the staff person was removed from patient care when an allegation of abuse was identified. The findings include the following:

- a. Patient #1 was admitted to the hospital's in-patient behavioral health unit on 1/14/19 with diagnoses of schizoaffective, bipolar and borderline personality disorders. Review of the nurse's note dated 3/11/19 at 7:30 PM by RN #1 indicated that the patient was yelling at the nurse's station and was directed to his/her room. RN #1 notified the patient's nurse (RN #3) that the patient was not redirectable and suggested the patient receive as needed (PRN) medication. The note indicated that the patient was assisted to his/her feet by RN #1 and escorted to his/her room. The patient was placed in the room with the door closed and attempted to open door. The patient was redirected back into the room with the door closed. The patient opened the door again and motioned toward RN #1. RN #1 placed a hand on the patient's shoulder and directed the patient back into the room. The note indicated that the patient lowered self to floor and stated that RN #1 pushed patient.

Review of hospital documentation of the incident identified that on 3/11/19, Patient #1 was yelling on the unit during report and RN #1 directed the patient to his/her room. The patient proceeded to the day room and RN #1 asked another RN to prepare an as needed (PRN) medication for the patient. RN #1 stated that he escorted the patient from the day room using CPI (Crisis Prevention Institute) techniques. He stated once in the room the patient attempted to leave the room.

RN #1 placed a hand on the patient's back to guide the patient, and the patient placed his/herself on the floor in slow motion which RN #1 identified was "not an actual fall".

Review of RN #2's statement identified that Patient #1 was yelling and he observed RN #1 place an open hand on the patient's back to escort the patient to his/her room. RN #2 stated that he went to the patient's room to assist and on arrival, RN #1 had the patient in his/her room with the door shut and was holding the door handle. RN #2 indicated that he could hear the patient talking through the door and the patient did not appear to be threatening or inappropriate.

Interview with the Psychiatric Nursing Director on 6/5/19 at 10:30 AM identified that on 3/12/19 she and the Manager were notified of an incident the previous night (3/11/19). On review of video of the incident, RN #1 was observed placing his hands on Patient #1, pick the patient up from a chair, place his hands on his/her shoulders and escorting the patient down the hall. The Nursing Director indicated that picking up a patient is against CPI training.

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Review of the hospital's video monitoring on 6/5/19 at 2:00 PM identified that on 3/11/19 RN #1 was observed walking the patient to his/her room, pushing the patient into the room, closing the patient's room door and holding the door closed for a brief period which is inappropriate seclusion of a patient. The video further indicated that when the door was opened by RN #1, the patient walked towards the door slowly with hands raised and as he/she got closer to the door, RN #1 raised his hand, placed it on the patient's left shoulder and pushed the patient back, causing the patient to stumble.

The facility failed to ensure that the patient was free from abuse and seclusion.

Review of the Rules of Conduct policy indicated that violations of the rules of conduct are in part unprofessional or inappropriate behavior, threatening, intimidating or coercing patients, and visitors at any time.

- b. Interview with the Clinical Resource Leader (CRL) on 6/5/19 at 11:15 AM indicated that on 3/11/19 when she arrived to the unit at approximately 7:00 PM Patient #1 informed her that RN #1 had pushed him/her. The CRL indicated that she and RN #3 assessed the patient and no injuries were noted. Patient #1 denied injuries however was upset and angry. The CRL indicated that she spoke with RN #1 who denied pushing the patient but felt like the video would look like he did. The CRL remained on the unit throughout the night and stated that she did not feel that RN #1 was a danger to patients. The CRL stated that she did call to see if she could view the video but did not have access.

Interview with the Nursing Director on 6/5/19 at 10:30 AM indicated that she was notified of the incident on 3/12/19 in the morning and reviewed the video of the incident. Based on the review RN #1 was suspended with pay and subsequently terminated on 3/18/19 based on lifting the patient out of a chair, inappropriate seclusion and pushing the patient.

Subsequent to the event staff were reeducated starting on 3/12/19 on proper technique for CPI escorting and therapeutic holds and reeducated on seclusion and chain of command. Restraint and seclusion education, related topics and audits were added to Daily huddles and are on-going.

The facility failed to ensure that RN #1 was removed from patient care when an allegation of abuse was identified.

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2. *Based on clinical record review, interview and policy review for 1 of 3 patients (Patient #1) the facility failed to ensure that a patient was placed in seclusion based on a physician's order. The findings include the following:

c. Patient #1 was admitted to the hospital's in-patient behavioral health unit on 1/14/19 with diagnoses of schizoaffective, bipolar and borderline personality disorders. Review of the nurse's note dated 3/11/19 at 7:30 PM by RN #1 indicated that the patient was yelling at the nurse's station and was directed to his/her room. RN #1 notified the patient's nurse (RN #3) that the patient was not redirectable and suggested the patient receive as needed (PRN) medication. The note indicated that the patient was assisted to his/her feet by RN #1 and escorted to his/her room. The patient was placed in the room with the door closed and attempted to open door. The patient was redirected back into the room with the door closed. The patient opened the door again and motioned toward RN #1. RN #1 placed a hand on the patient's shoulder and directed the patient back into the room. The note indicated that the patient lowered self to floor and stated that RN #1 pushed patient.

Review of hospital documentation of the incident identified that on 3/11/19, Patient #1 was yelling on the unit during report and RN #1 directed the patient to his/her room. The patient proceeded to the day room and RN #1 asked another RN to prepare an as needed (PRN) medication for the patient. RN #1 stated that he escorted the patient from the day room using CPI (Crisis Prevention Institute) techniques. He stated once in the room the patient attempted to leave the room. RN #1 placed a hand on the patient's back to guide the patient, and the patient motion placed his/herself on the floor in slow which was "not an actual fall".

Review of RN #2's statement identified that Patient #1 was yelling and he observed RN #1 place an open hand on the patient's back to escort the patient to his/her room. RN #2 stated that he went to the patient's room to assist and on arrival, RN #1 had the patient in his/her room with the door shut and was holding the door handle. RN #2 indicated that he could hear the patient talking through the door and the patient did not appear to be threatening or inappropriate.

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Review of the hospital's video monitoring on 6/5/19 at 2:00 PM identified that on 3/11/19 RN #1 was observed walking the patient to his/her room, pushing the patient into the room, closing the patient's room door and holding the door closed for a brief

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Subsequent to the event staff were reeducated starting on 3/12/19 on proper technique for CPI escorting and therapeutic holds and reeducated on seclusion and chain of command. Restraint and seclusion education, related topics and audits were added to Daily huddles and are on-going.

Review of Restraint and Seclusion policy indicated that seclusion should be initiated if alternatives are unsuccessful, and based on a provider order. When a patient is in seclusion the patient is to be monitored constantly with the patient in the direct field of vision.

**The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e)
Nursing Services (1) and/or (i) General (6).**

3. Based on clinical record review, interview and policy review for one patient (Patient #1) the facility failed to ensure that a physical assessment was documented in the clinical record. The findings include the following:

Patient #1 was admitted to the facility on 1/14/19 with diagnosis of schizoaffective disorder, bipolar and borderline personality. Review of the nurse's note dated 3/11/19 at 7:30 PM by RN #1 indicated that the patient was yelling at the nurse's station and was directed to his/her room.

Review of hospital documentation of an incident identified that on 3/11/19, Patient #1 was yelling on the unit during report and RN #1 directed the patient to his/her room. RN #1 placed a hand on the patient's back to guide the patient, and the patient placed his/herself on the floor in slow motion which RN #1 identified was "not an actual fall".

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The clinical record failed to identify an assessment of the patient following an allegation of being pushed by staff.